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ABSTRACT

Teachers can engage in practical reflection through collaboration that enriches their sense of what is feasible and possible, and they can transform their understanding of those realities. Critical reflection, however, requires various forms of assistance. The use of "clinical supervision" over 6 months in 1982 with 14 teachers in 4 primary schools and a high school, was based upon cooperation, consultation, observation, and feedback among teachers. The method used was neither "clinical" in the pathological sense, nor "supervisory" in the quality control sense. Rather, trusted teaching colleagues assisted each other to analyze their teaching through cycles of observation, analysis, and discussion of data to establish shared frameworks of meaning within which improvement was possible. The effect was that teachers were able to exercise a greater degree of control over their work environment, and the direction and pace of their own professional development. Through clinical supervision, teachers became active and conscious agents in the determination of their own practice, rather than passive channels for other people's agendas. (JD)

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CASE STUDY EXPERIENCE OF A COLLABORATIVE AND RESPONSIVE FORM OF PROFESSIONAL DEVELOPMENT FOR TEACHERS

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ABSTRACT

The argument in this paper is that teachers' interpretations and theories about what works in classrooms, can and should constitute the basis of change. Teachers have the capacity to engage in practical reflection through collaboration that enriches their sense of what is feasible and possible as well as transforming their understanding of those realities. Critical reflection, however, requires various forms of assistance, and in this case it occurred through the provision of a paradigm, the Cogan (1973)/Goldhammer (1969) notion of clinical supervision.

Our use of clinical supervision over six months in 1982 with 14 teachers in 4 primary schools and a high school, was based upon co-operation, consultation, observation and feedback between and among teachers about each others' teaching. It was neither 'clinical' in the pathological sense, nor 'supervisory' in the quality control sense. Rather, trusted teaching colleagues assisted each other to analyse their teaching through cycles of observation, analysis and discussion of data to establish shared frameworks of meaning within which improvement was possible. The effect was that teachers were able to exercise a greater degree of real control over their work environment, and the direction and pace of their own professional development. Teachers became active and conscious agents in the determination of their own practice, rather than passive channels for other people's agendas (Smyth, 1982a).

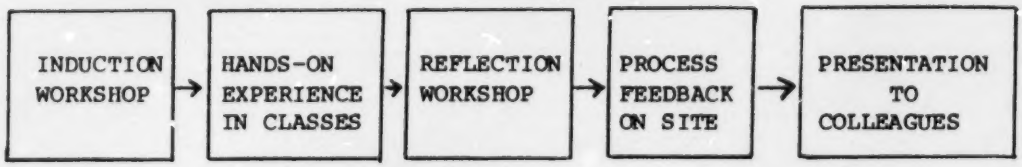
Following-through In-Service Activity

Introducing teachers and principals to clinical supervision over the years, has convinced us that one-shot in-service workshops have no respectable history and no likely future. Besides, we felt uncomfortable with the label of experts. We certainly knew nothing of the teaching strengths of individual teachers, their teaching concerns, or their specific classroom contexts. We were more at ease with the tag of 'facilitators' - co-workers helping teachers to gain insights and develop ways of working together to gain appropriate personal knowledge about their own teaching. Our problem was finding a way of working with teachers that acknowledged their legitimate aspiration for control and ownership, while recognising the need for outside support, encouragement and coaching as they came to grips with the realities of their teaching.

Our 'follow through' in-service model (Smyth, Henry, Marcus, Logan & Meadows, 1982) provided a way of helping teachers incorporate clinical supervision into their teaching: it comprised workshops, practical in-school experience, observation visits by us to their schools, and reports by the teachers to teaching colleagues within their schools. Unlike many in-service activities, our five part model was an attempt to provide follow-up support and assistance to teachers as they experimented with clinical supervision.

Figure 1

A Follow-Through Model of Working with Clinical Supervision



1. An induction workshop: Self-selected pairs of teachers were introduced to the concepts and practicalities of clinical supervision at a one day workshop; they were also asked to give it a 'provisional try' in their schools, and report on the experience at a subsequent workshop.

2. A hands-on phase: Participants implemented an agreement they had entered into with each other at the workshop, to give clinical supervision a try. They kept a diary of their experiences.
3. A reflection workshop: The original group reconvened to share experiences gained through using clinical supervision. For those who continued, there were two more phases.
4. Process feedback on-site: Some teachers allowed us to visit their school, observe them as they implemented clinical supervision, and provide them with descriptive feedback to fine-tune the process so that they could make whatever adjustments they felt were necessary.
5. Presentation to colleagues: Reporting to other teaching colleagues on successful experiences with clinical supervision was important. As well as sharing a willingness to keep colleagues informed of innovative practices being tried in the school, actually providing an experience-based account of an innovation gave teachers an opportunity to legitimate what they had been doing, to reflect on the efficiency of their efforts, and to invite others to become involved in the innovation, if they felt so inclined.

On What was Learned

We believed we gained some important understandings about introducing clinical supervision to teachers.

Induction Workshop: During the induction workshop when teachers first heard about the concept of clinical supervision and were shown what it looks like via videotape, they were given an opportunity through discussion to explore with others in a similar situation to their own, 'how this is going to affect us'. This opportunity to project forward, to foreshadow problems, and to formulate strategic responses to potentially worrying issues, was an important part of making real linkages between the theory of clinical supervision and the practicalities of how it worked in down-to-earth teaching situations. A crucial aspect for each pair of teachers likely to be working together, was the opportunity to think and talk through an aspect of their own teaching that they could focus upon on returning to their school.

Developing this commitment to action before the conclusion of the first workshop was a centre-piece of the whole process. The overall importance and significance of a prior commitment to action should not be under-rated. Too often, promising new ideas generated in workshop situations fail to take hold in schools simply because the press of everyday realities associated with schooling tends to crowd out all but those aspects of teaching to which teachers have an unassailable commitment. Leaving the induction workshop after having made two commitments, (one to a trusted colleague, and the other to the group), to give clinical supervision a try, was an important advance over traditional in-service strategies.

This workshop was an enlightening experience because its purpose, intent and structure were quite contrary to the way in-service activities are normally conducted for teachers. There was even something of an implicit contradiction in what was being attempted. The activity had certainly been labelled as an 'in-service activity', but as 'outsiders' we tried not to enact the role expected of us as providers of pedagogical wisdom. What we had to offer may not have appeared to be particularly profound; getting teachers to look at what goes on in ordinary, everyday teaching, might not seem to be 'innovative' at all. Starting from where teachers are actually 'at' in their development as professionals seems to be a deceptively simple idea. It is interesting to note that in reconstructing the events of this workshop some time afterwards, we could detect that <u>some</u> teachers were inclined to interpret our intentions at other than face value. The result was an unnecessary tension within themselves which, while in some ways understandable, was nevertheless regrettable. Questions like 'What are they <u>really</u> up to?' 'Where are their unstated motives?' indicated suspicion of a hidden agenda. That teachers' knowledge has not been highly prized by outsiders in the past, and their feelings and thoughts more often neglected than valued, did not make it any easier for these teachers to accept the notion of clinical supervision as a responsive, teacher-controlled form of staff development.

For the majority of participants, the experience of the first one day workshop was sufficient to convince them of the authenticity of our stated purpose. We were not there in any kind of guise; we were doing what we had outlined as our mandate at the beginning, namely, trying to

help them isolate areas of their teaching they might look at, with some guidance about a strategy that might enable them to do things they wanted done. Several indicated afterwards, that the workshop had been a liberating experience for them. The comments speak for themselves:

> Knowing that it was possible to have another teacher come into your classroom to give you positive help without criticism, was really important. A lot of teachers don't realise that is possible,

was a comment from one teacher.

All was not sweetness and light immediately, of course. One teacher admitted to being quite sceptical before coming to the workshop, but left with quite a different impression: "I was impressed that clinical supervision was a reciprocal kind of arrangement ... both partners had an equal role to play." The same teacher echoed a sentiment felt by almost al others who attended this workshop: "It was interesting to hear and compare other teachers' concerns." From another: "... it was reassuring to hear that other teachers had common teaching concerns to my own."

This opportunity to talk about areas of their teaching that might be problematic, and to hear from others, was a theme that constantly emerged in comments about the induction workshop. One teacher found it especially useful to be able to leave the workshop with a blueprint which indicated precisely how a colleague was going to look at her teaching upon returning to her school. Another indicated the practicality of plans made at the first workshop when she said: "I actually used the focus I isolated at the workshop during my first cycle of clinical supervision." Although the proceedings of the day were action-oriented and required people to decide to do something in the presence of a colleague, one teacher valued the reassurance she gained:

> I was assured that we were not going to be critically looked at. The events of the day made it clear that we were looking at concerns in our own teaching, and this made me feel much better.

That teacher left the workshop still a little concerned, but the concern was more to do with how she was going to play her role as a helping observer rather than a worry about being critically scrutinised. The most important outcome of the day's activity for another teacher was finding that:

> Another staff member was willing to work in partnership with me, and help me in my professional development, and allow me to participate in a similar manner.

There is an important point that emerges from all of this. Clinical supervision is certainly a common-sense notion, certainly a simple concept in many ways. What the teachers at this workshop indicated was that common-sense, does not always equate with common or widespread practice. People were able to accept the inherent sensibility of systematically analysing their teaching with a quite deliberate purpose in mind, and could appreciate the advantages of and using the help of a trusted colleague to do so. What was revealing, however, was that little of this apparently 'common sense' practice had been actually occurring in any school before the workshop.

An issue that was not altogether clear at the start of the project was how and why this particular group of teachers actually came to be involved in the project. Apart from the fact that they came from schools where principals had an initial interest in clinical supervision, we knew little about motives or aspirations when we began. As the project progressed through its various phases, the personal agendas of the people did become more apparent. To what extent did teachers select themselves into the project? To what extent were decisions about involvement taken collectively by the staff after being informed about what was involved?

These were not only significant questions, but they were ones that had a profound effect on the success or otherwise of the entire activity. We found that involvement in making early decisions about who becomes involved in innovations, has a direct and cumulative effect on final outcomes. It seems obvious enough to argue that ventures like clinical supervision that depend so much on voluntary involvement, trust, and mutual collaboration between teachers, must give due regard to the way in which participants come into the activity. This was not appreciated at the start by everyone involved.

One requirement we made, as organisers, was that volunteer teachers who attended the workshop come in 'working pairs' or with 'buddies', so that on return to their schools they would be able to actually do clinical supervision with their partner. It is no mere coincidence that

the schools which sent more than one representative to the first workshop all continued beyond the induction phase, whereas only one of the schools with a single participant made it beyond that stage.

Indications of a positive response to the extended 'follow through' in-service format was evident as early as the initial induction meeting. Teachers, for instance, expressed their agreement with our version of the limitations of the one-off style of in-service activity, and responded enthusiastically when given the opportunity to plan for specific in-school trials of the clinical supervision process. The most compelling evidence of their satisfaction with our launching of clinical supervision on this occasion was the subsequent appearance of almost all the original 'starters' at the follow-up reflection workshop which was held one month after the original meeting.

It would be a mistake to lose sight of the real intent of the induction workshop. It was a familiarisation exercise with a practical follow-up component built into it. Each pair of teachers was given an opportunity to tailor-make the kind of in-service he/she would like to 'try out' in their school. Each departed from the workshop with knowledge about clinical supervision, with a clearly identified aspect of teaching to be examined back at school, and with a set of concrete plans for beginning their inquiry. Each had <u>made a commitment</u>; not a commitment to adopt clinical supervision in any kind of permanent way, but simply a commitment to <u>give it a try</u>. At the conclusion of the workshop, each person had a clear understanding that the group would reassemble in four weeks time when its members would relate their experiences to others who had made similar efforts. There was no compulsion, no coercion, only a commitment to colleagues that if they returned they would do so with a willingness to exchange recollections and reflections about their experiences.

<u>Hands-On Experience Phase</u>: Our own research work did not provide us with any direct data about this aspect of the project. We left implementation of clinical supervision in the hands of teachers. The first workshop had provided them with the theory and some demonstration of clinical supervision, what they in addition needed was practice at using the process. The only requirements we wanted people to accept were that they

follow the principles of clinical supervision as outlined as the workshop, and that they be prepared to report on their experiences at a follow-up workshop. For this purpose the experimenting teachers were provided with a selection of guiding questions to think about as they implemented the process and invited to prepare a one page summary of their experiences of enacting clinical supervision to be shared during the coming workshop.

Reflection Workshop: The process of assisting teachers to reflect on their practice was a more complex matter than we had first thought. Simply inviting pairs of teachers, or clusters of teachers within schools to utilise the clinical supervision process in their own classrooms was hardly sufficient to guarantee the innovation a fair trial. The idea of mutual support on a wider scale was crucial to the success of clinical supervision, especially in the early or formative stages. We found out that teachers needed a supportive forum in which they were able to share their first-hand experiences with each other, while hearing about the problems, successes and achievements of others who had been through similar experiences. Had we omitted to provide this opportunity for sharing lived-experiences, we would have seriously under-rated the importance of the kind of support and encouragement that teachers can provide for each other when trying out new ideas.

In articulating their thoughts and feelings about clinical supervision, the participating teachers were able to provide a number of significant insights. For example, almost everyone who had tried clinical supervision was apologetic for not having completed more than one or two cycles in the four weeks since the induction workshop. What was surprising for us was that teachers had expectations that in their already crowded schedules it was possible to achieve much more than they actually had done. This in itself was a sobering experience for many, but as a result of their joint efforts they were able to come to a collective realisation that engaging in reflection of the kind implicit in clinical supervision, takes substantial amounts of time. Without additional resources, the limitations on what it is possible to achieve in work of this kind, become quite obvious.

The way in which most of the participants became involved in the program in basically a self-selecting way, also emerged as an issue. While it is difficult to envisage participants becoming successfully involved in clinical supervision on other than a voluntary basis, it became apparent that this kind of elective participation also has its drawbacks. The major difficulty was that of developing a community of people who were involved in clinical supervision at any one site. On-going discussions among participating teachers, were therefore quite circumscribed. Even at one site where there were a number of partners working together, one teacher indicated that lack of discussion about what was happening had led to feelings of isolation. He felt that he would have benefited from more discussion with his colleagues at the time. His major regret was that of having to contain his feelings and not being given an opportunity to share them, until the second workshop.

The most tangible benefit from the second workshop was the teacher-to-teacher exchanges that occurred in a context of mutual encouragement and support. While this was deliberately planned because of our conviction that teachers have a great deal to offer each other, it was a surprise to some teachers to learn what could emerge from these exchanges. One person expressed it in these words:

> I really appreciated the personal contributions of other teachers - being able to listen to their doubts and concerns and finding that they often matched mine.

Such generous sentiments were also echoed by others. As well as promoting a clearer understanding of the advantages of collaborative learning and mutual support, the second workshop also represented something of a breakthrough in converting ideas into action.

In contrast to the common and often disappointing experience of many in-service activities, where good ideas are presented and applauded but never actually materialise in teachers' practices, it became clear on this occasion that new ideas actually had been tested in practice. The immensely difficult task of overcoming personal and social intertia and concretely changing personal and institutional practices had been begun. As teachers discussed their experiences there was an increased realisation of the relationship between action and knowledge and an appreciation of the strategic value of constructing circumstances that require practical action rather than mere speculation or supposition.

The expectations which people actually had about the usefulness of clinical supervision, and what they actually experienced, provided some interesting contrasts. The process of requiring participants to prepare a brief written report to be presented to the group at large, had important and productive effects. This was in part linked to the commitment that people had made at the end of the induction workshop to give clinical supervision a try, and then return and report to the group on what had happened. There was a strong sense of colleagial support and responsibility among those who continued on to the reflection workshop. The indications were that although the idea of making a presentation in front of colleagues was not without its anxiety, it was nevertheless construed as being a worthwhile activity. For many of those who took part the real utility of the second workshop lay in learning about the variety of ways in which colleagues had been able to take up the process, and in confirmation of individual impressions. Some of the teachers' comments worth noting include:

> I really came to the workshop feeling that listening to each other would be repetitive. I was pleasantly surprised to find that there was a variety of situations. I was very interested to hear others' experiences and impressions.
>
> This was an intimate session where I felt I could speak honestly without being embarassed. I was really surprised at how comfortable I felt when it was my turn to speak. These situations are usually pretty tense for me.
>
> I thought this was an excellent day. I realised that nearly all the other teachers faced the same sort of problems we did ... Just to hear how other teachers used clinical supervision, gave me many ideas about my own teaching.
>
> It gave me an indication of many varied and different ways clinical supervision can be used. It also illustrated that all teachers have areas of concern, not just me, and it (clinical supervision) is not just for poor teachers.

Even one member of the group who was quite negative about his practical encounter with clinical supervision because of the difficult conditions which prevailed while he tried to implement it allowed some optimism to emerge through an unguarded statement:

> I didn't want to go (to the reflection workshop). I couldn't see much purpose in it. I must be quite honest in that I was amazed that the time went so quickly, for me anyway ... So, that in itself showed there was some interest (for me) ... I found it very interesting, but as far as gaining anything, I don't think I gained anything at all.

In effect what the second workshop revealed was the participants' willingness to go along with our two explicit expectations. (The first, was that attendance at the reflection workshop implied an agreement to actually trial clinical supervision; and the second, involved publicly reporting personal findings arising from this experience to others similarly engaged in the same experimental work.)

At the most practical level, the experience of actually reconstructing the events of how they used clinical supervision, the context in which it occurred, and with what effect, provided a neat series of case studies for other participants to think about in comparison with their own situations. The fact that other teachers had actually tried ideas, and found them to work, was an important piece of information.

Discoveries about aspects of their own teaching were personally significant for these teachers. For example, the teacher who wanted information about the clarity of her directions to students, found that: "The data confirmed many things I thought I did. It helped me see that my directions were vague." And on another occasion where a teacher's concern was about the engagement of students during a creative writing lesson:

> The data, by and large, confirmed what I thought was happening to childrens' work patterns. However, we found one kid, with a low output of work, yet the data clearly showed that he worked hard all the time. This was revealing to me.

One important finding was that classroom occurrences are not always what they seem to be. Where unexpected discoveries like these occurred, teachers were prompted to realise that there were other related questions that needed to be asked; questions like, 'How can I devise ways of ensuring that when children are apparently working, the tasks that are set for them are in fact meaningful?' For the teacher, this indicated a

significant next step to be taken. For the observer, it was an invitation to ask himself equally significant questions such as, 'Do the children have to be sitting up straight and working industriously, to be learning?' Other teachers made important discoveries about their interpersonal relations, and how the clinical supervision model might need to be changed so as not to interfere with important human relationships.

Learning that clinical supervision could work in secondary schools as well as in a range of situations in primary schools; that it had uses in social situations outside classrooms (such as teachers' meetings); that it made unexpected demands on personal and interpersonal resources; that it sometimes required learning about data gathering skills; that it often depended on altering timetables; that it required the goodwill of other colleagues; and, that it involved adding more tasks to already crowded work schedules - were all inescapable lessons for teachers who experimented with clinical supervision. Not all these experiences were endearing it was true. Some experiences were trying, others unpleasant, still others frustrating and disappointing. But regardless of impact, the crucial factor was that participants were able to convey to each other personal knowledge gained through participation in the program. The ideas canvassed were ones that had been tested out in practice. Moving beyond the stage of talking or speculating about what clinical supervision would add up to when tried, gave a great deal of credibility and authority to the teacher-to-teacher exchanges that took place at the reflection workshop. Personal impressions, chastened by comparison with others' experiences, were powerful means of confirming the reliability of each person's contribution. Authentic and believable insights depended to a large extent on the capacity of teachers to present to each other, 'true to life' experiences.

Experience probably always precedes understanding. On this occasion the expectation that participants would plunge in and actually try the clinical supervision process, enabled them to know things about clinical supervision that they could not have known otherwise. As one teacher candidly put it:

> I understand it a great deal better now that I have actually done some clinical supervision ... There are benefits from observing and seeing the difficulties involved in recording the data ... It's all very well to read about those things, but to actually participate and see the benefits that come from it ...

Process Feedback On-Site: No amount of theory about, or practice with, a new idea is likely on its own to guarantee incorporation of that idea into a teacher's practice. Even where teachers develop facility in using a new skill in practice situations, this is still insufficient. What is required also is focussed feedback of a non-judgemental, descriptive kind that informs the teacher of the impact of the new strategy. In a word, there is a need to provide for 'coaching' (Joyce and Showers, 1982) as teachers experiment with new ideas like clinical supervision.

In our project, not all of the schools and participants we started with stayed with us. Some soon decided to abandon the experiment; that was a decision they were free to make. Those who decided to continue were offered additional support as they continued experimenting with clinical supervision. Our plan was to visit the sites where clinical supervision was being tried, to observe the teachers using the process, to collect data about their implementation of the supervisory process, and to discuss this with them in a constructive way.

Despite our perception that what we were doing was assisting interested schools to learn more about the implementation of the clinical supervision process, it became apparent that our perceptions did not always match those of our hosts. A number of teachers had a considerably less enchanting view of the purpose of our visits! One impression was that we were 'checking up' on schools, and creating a degree of pressure on them to keep things moving. Another was the expectation that we would be 'hard' on people in the schools; hard to please and hard to put up with. Our initial perception that we would be regarded more convivially was too naive. Of course we were creating pressure to keep things moving, as well as attempting to respond to the needs of those teachers prepared to persist with the innovation. But we were surprised by the inspectorial associations we evoked, and by the way these caused us to be regarded. We were especially surprised by the way attitudes to our presence came out in one place as more than mild resentment and the feeling that we were pushing people to do something they were reluctant to do. In another school some of the same worries emerged as a perception that we would be rather tough, critical, and uncompromising. Schools and teachers each have their own histories, but our evidence suggested that a residue of anxiety and even suspicion continues to

exist, and this makes outside change agents appear to be 'on the other side' and opposed to teachers. Merely claiming to be responsive to teachers' needs is not enough to dispel these doubts.

The extent to which we were able to 'live down' the reputations of our inspectorial predecessors depended to a considerable extent on the way in which our presence was construed. We were able to be most helpful in those schools where the greatest time and effort had been devoted to giving clinical supervision a fair trial. We were least effective where people felt obliged to go through with an initiative they found burdensome and difficult to remain committed to; in these schools our presence was seen as having an evaluative intent.

In a number of situations the usefulness of the feedback provided during site-visitations was clear from the comments made by teachers who had been through the experience. For one experienced teacher:

> ... the clinical supervision process is not yet a permanent feature of this school. If it were to become so, we could all benefit from the continued encouragement and support we have received to date, particularly in the early stages of implementation.

One teacher candidly admitted to being:

> a little overawed (about the idea of your visiting) my room ... there was a little apprehension and uncertainty in my mind about what was going to happen.

Another teacher had two quite different sets of feelings before and after the visitation:

> I felt very anxious about your visit to see us in action. Although you tried to impress upon us that you just wanted to see the process as we were implementing it, I still felt rather threatened ... Afterwards I regretted having (expressed my anxiety) because I actually found the (discussion) session with (you about) clinical supervision quite enjoyable. Thank you for your relaxed approach which helped me feel quite at ease in the classroom and during the post-observation conference afterwards.

Presentation to Colleagues: In those schools genuinely trying to find out how clinical supervision worked in practice, it was possible to overcome teachers' initial apprehension about what would happen when the

innovative work being attempted was exposed to outside scrutiny. Here it was possible to offer assistance with various aspects of the clinical supervision process (with practical data gathering methods, for example); to provide encouragement and support to those struggling to master the new process; to play a supportive role in reporting the progress of the innovation to the school staff generally; and to suggest possible avenues by which clinical supervision could find a place in the future life of the school.

None of that facilitation was possible in situations where clinical supervision was not wanted. In those circumstances our presence was an embarrassment; we were outsiders exerting unwanted pressure to complete agreements previously entered into to make things happen. People felt as if they were responding to us, not the other way round. Our role was more or less determined in advance for us by those we thought we were assisting and it was distorted out of recognition in the process of redefinition. We became apologists for clinical supervision in a hostile environment, and nobody benefited from the experience. One participant who did not go beyond the workshop phase, failed to appreciate the supportive intent behind our visit:

> I can't see the point in your coming in to see what's happening at all. If we are having trouble, yes, I can see that. But I can't see the point of you coming in to see the process at work.

The comparative perspective made possible by considering developments across a number of schools indicated illuminating relationships between the success of the experiment with clinical supervision and the context in which the innovation was attempted. Of the contextual factors that strike us as most significant, the involvement of the principal stands out as vitally important. The way the principal associated himself with the new venture in each case had a decisive effect on either making or breaking the innovation. All principals made it possible for teachers from their schools to attend the induction and reflection workshops. Where teachers wished, the principals also made it possible for teachers to take advantage of our consultancy services during our visits to schools. Enabling teachers to be involved in the first instance, and then to continue to be involved, was of course an essential facilitating role. Beyond that generality, however, the pattern was less uniform and

it is possible to identify three distinct styles of principal involvement. The first style might be described as 'implicit support' for the clinical supervision initiative; the second as 'active support'; and the third as 'negative support'.

'Implicit support' might be portrayed as the principal saying to the clinical supervision 'pioneers' on his staff:

> I have no objection to your trialling this new idea. You should go ahead with whatever it is you want to do feeling you have my approval and support.

Underpinning this approach is a belief in the maturity and autonomy of staff members and a recongition of their professional competence. It represents co-operation between a principal and his colleagues and a willingness to permit innovative active members of staff to make their own running. Implicit support does not however, include, active involvement in the project. It therefore runs the risk of making a principal appear uninterested in the innovation taking place within the school. This is always a danger that someone operating behind the scenes has to consider. Taking a low profile can be interpreted as lack of interest, especially where interest is gauged in terms of active involvement, explicit statements of support, and tangible signs of interest. Innovations may founder when teachers feel that what they are attempting lacks adequate support from the school's leadership.

'Active support' is open to less misinterpretion about the principal's regard for an innovation. It encompasses a variety of expressions of interest in the work of teachers of introducing changes, such as clinical supervision, into a school. It goes further than symbolic involvement. Active support means collaboration; it means the principal actually becoming involved with teachers in making change happen. It means getting his hands dirty, as it were. Talking with teachers about the changes they are struggling to make, registering the value of their efforts with colleagues in public forums such as staff meetings, choosing to involve popular and competent staff members in new pushes - these are all necessary when it comes to creating the sort of climate in which teachers can feel that working to renew their professional practice is worth doing. Even more important than verbal support of this kind, however, may be the extent to which a principal involves himself alongside his

teachers. When a principal is also prepared to throw himself into work his teachers are attempting, (for example, by taking classes so that teachers can obtain time to engage in the joint planning, action, and reflection that clinical supervision requires), then he expresses a commitment to the innovation which words alone cannot express. When he carefully plans and stages a staff meeting for the express purpose of enabling innovators to share their practical findings with their colleagues, he does the same thing. And he further confirms his commitment to practical improvement when he agrees to act as an observer or data gatherer for one of his colleagues.

'Negative support', on the other hand conveys the ambiguity and ambivalence of situations in which action can be interpreted as conflicting with rhetoric. It might be described like this. Imagine a principal talking to one or two selected 'volunteers':

> Young inexperienced teachers might be able to learn something from this clinical supervision. They might get to know some of the important practical teaching skills they should have been given during their training. Clinical supervision is only likely to be useful for beginning teachers. There's nothing in it for experienced practitioners.

The basic difficulty with this approach is that it stigmatises users of the innovation. Adopting the change becomes a way of admitting difficulties in a situation where having difficulties with teaching is assumed to be an abnormality. The more the view is espoused that clinical supervision is a treatment that only incompetent teachers need to undertake, the less likely it is that teachers will want to be identified with the innovation. The problem is compounded if time constraints and other practical difficulties that have to be attended to if the experiment is to have any hope of being successful, are construed unsympathetically. It is exacerbated further if the notion of 'collaboration' with outsiders, such as university consultants, takes on the meaning of co-operation with those interfering with school affairs, and it becomes insoluble if confrontational situations arise where exponents of clinical supervision know that supporting the innovation means alienation from one's work-mates. None of this is a formula for success.

Some Emerging Understandings

If we can summarise our findings!

There is little evidence to suggest that oppressive forms of supervision and surveillance of teachers actually produces any desired effect. Rather, the reverse appears to be true. It is not sufficient either to argue that the mere absence of oppression equates with processes of enlightenment, growth and development of teachers.

Our work led us to the conclusion that trust, colleagiality and collaboration are seriously violated if teachers are co-erced into processes like clinical supervision. While teachers stand to gain from involvement in processes of this kind regardless of length of teaching experience, it must also be acknowledged that it may not have equal appeal for all teachers. Where they do decide to give it a try, they appreciate the opportunity of exploring its implications with a trusted colleague in a workshop situation that has as its focus the 'back at school situation'. After they have made the first tentative trials, teachers benefit from sharing their concerns and experiences with other colleagues at the same stage of implementation and experimentation.

Supportiveness comes in various forms. Teachers trying new ideas need understanding, support and encouragement (in more than words) from the principals in their schools. Providing the time for it to happen, is an obvious form of assistance. Getting the process started and sustaining it requires assistance, encouragement and feedback from others outside of the school.

Above all we are convinced that clinical supervision provides a powerful means of converting ideas into action. By providing a way of actually trialling new ideas, it overcomes many aspects of personal and social inertia which prevent change from occurring. Experience provides meaningful personal knowledge which moves teachers beyond the stage of merely guessing, speculating or imagining what will happen when they put an innovation in place. Getting an innovation off the ground is no guarantee that it will soar, but passing the take-off stage at least provides meaningful knowledge of what it is like to fly.

We are sensitive to the fact that such programs also have a way of exposing cosmetic changes, and can prove to be uncomfortable in circumstances where changes are misunderstood, adopted symbolically, or rejected prematurely. Responsive in-service programs that intend to respond to what teachers believe needs to be done, are not universally well understood for what they are. Assisting teachers to identify and diagnose practical problems of importance to them, and over which they exercise discretionary control, is an ideal capable of being misconstrued. Responsiveness can still be regarded as a camouflaged means of 'pushing teachers around'. Schools can adopt or reject changes; they can engage in critical enquiry about their work, or complacently continue with habitual practices; they can be open to new ideas, or cling to what has always been done; they can seek to understand and bridge the gap between their rhetoric and their reality, or they can live with incoherence and contradiction. Decisions about the life of schools for most practical purposes, are made within them. Co-operation is clearly the key. Without the active co-operation of teachers, principals, superintendents, consultants, regional in-service organisers and others, the scheme cannnot work. Voluntary involvement is the nature of school-controlled in-service education, and co-operation the only congruent way of working with others.

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